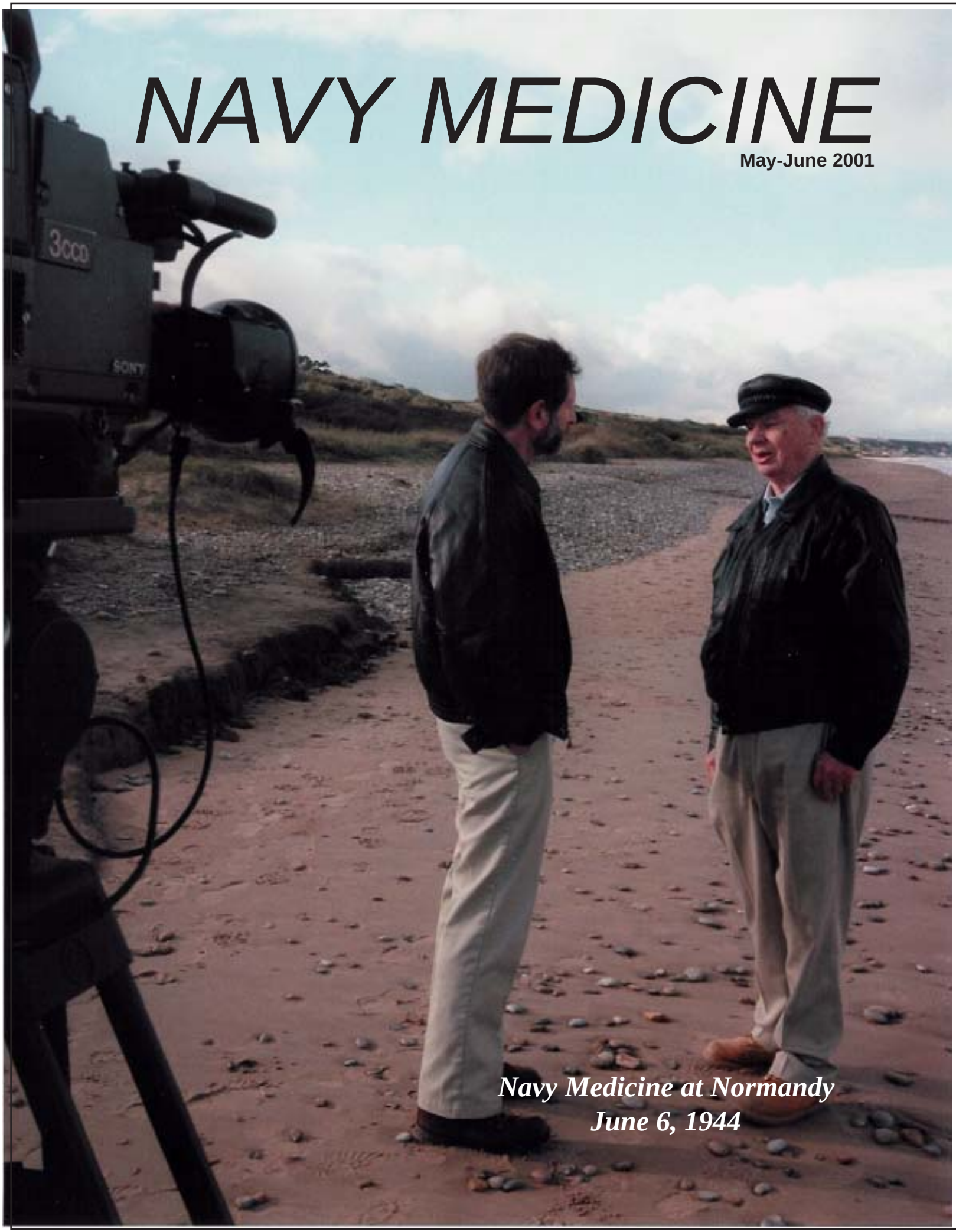
NAVY MEDICINE

May-June 2001



Navy Medicine at Normandy
June 6, 1944

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COVER: "I came ashore right here." 6th Naval Beach Battalion veteran Dr. Lee Parker describes the landing on Omaha Beach to Navy Medical Department Historian Jan K. Herman. The Bureau of Medicine and Surgery will soon release the second video in the series on Navy medicine in World War II. Story on page 10. Photo by John Lewin.

New Laser Vision Center Opens at NNMC

LCDR Ed Austin, USN

The National Naval Medical Center (NNMC) opened a laser refractive surgery center under the Navy's Corneal Refractive Surgery Program, which makes the surgical procedure available to active duty Sailors and Marines. The new facility, located in the Ophthalmology Clinic at NNMC, started screening candidates for the surgical program in October and conducted its first laser surgeries in mid-November.

The program is intended to serve those active duty members whose mission effectiveness and personal safety would be most enhanced by eliminating the need for wearing eyeglasses or contact lenses while performing their military duties. Although active duty Navy and Marine Corps personnel may request evaluation to determine suitability for surgery regardless of job specialty or warfare community, priority will be placed on Sailors and Marines whose military duties require them to work in extreme physical environments that preclude the safe use of glasses or contact lenses.

Among the first to have the procedure done at NNMC's new Laser Vision Center was a group of Sailors assigned to the Experimental Diving Unit in Panama City, FL. According to BM1 Troy Larck, who wears contacts when he dives, this will eliminate the need for wearing lenses. "I have had a contact lens slip out of place during a dive, and there is not much you can do about it while you have your helmet on." QM2 Randall Chase, who has never been able to wear contact lenses comfortably due to his astig-

Photos by HM1 Jim Moyer, Medical Photographer

The center's director, CDR Joe Pasternak, MC, performs one of the first PRK surgeries in the new NNMC Laser Vision Center.

The corrective procedure is accomplished in less than 30 minutes and is followed up by a visual exam.

matism, looks forward to not having to worry about eyeglasses. Both Sailors looked on as their shipmate HM1 Robert Huffman led the group getting the laser surgery. LCDR Greg Wheelock, Director of the Navy Explosive Ordnance Disposal Fleet Liaison Unit located in Indian Head, MD, was also among the first to have the laser surgery. Shortly after a post-surgical exam, he was able to read words on a sign that he would not have been able to read without his glasses before the surgery. His duties require him not only to perform underwater dives, but parachute jumping as well. He indicated that contact lenses can be awkward when parachute jumping, due to the airflow across the eyes. He will now be able to leave the lenses behind.

NNMC's Laser Vision Center offers the corneal refractive surgical procedure known as PRK or Photorefractive Keratectomy. The PRK procedure uses the laser to remove a small disc-shaped sliver of the central cornea. PRK, one of two FDA approved refractive surgery procedures, is currently the only procedure offered under the Navy program. LASIK, or Laser In-situ Keratomileusis, will not be offered until further studies being conducted in the military adequately establish its safety in the operational environment.

Members requesting PRK will be screened by an optometrist or ophthalmologist to determine if they are clinically eligible for the surgery. If clinically suitable, the member's unit commander must endorse the request and determine the member's priority level. Once a command-endorsed request is received, the NNMC Laser Vision Center staff will review requests for final determination of clinical appropriateness and priority.

The most time-consuming aspects of the process are pre-surgical evaluations and post-surgical followup care. NNMC's new center has four specially equipped examination rooms to perform the pre- and post-operative visits. The center has three refractive-surgery trained technicians and one optometrist to perform initial screening exams and counseling. There are currently nine doctors on staff at the center who will perform the laser procedure.

According to CDR Joe Pasternak, MC, director of the center, the NNMC Laser Vision Center becomes one of only three such centers available for corneal refractive surgery under the Navy program. He projected that with the new state-of-the-art equipment and available staff, the center will be able to offer the procedure to approximately 80 Sailors and Marines a month.

In addition to the new center at NNMC, the laser surgery is currently available at Naval Medical Center San Diego and Naval Medical Center Portsmouth, VA. More detailed descriptions about the priority groups, as well as sample forms and letters used to request the surgery are available on the Navy Bureau of Medicine and Surgery website at: navymedicine.med.navy.mil/PRK/refractive_surgery_information.htm.

For more information regarding the services offered at NNMC's Laser Vision Center, call (301) 295-1200. The clinic's hours of operation are 7:30 a.m. to 4 p.m., Monday through Friday. ❑

LCDR Austin is the Public Affairs Officer at the National Naval Medical Center, Bethesda MD.

Preparation for the eye surgery includes removal of the surface layer of the cornea using an amoil brush.

New Medical Department Flag Selections

CAPT Michael S. Baker, MC, is currently assigned as Staff Medical Officer for NR STRATCOM 1362 at Offutt AFB, Omaha NE.

CAPT Baker received his bachelors degree at University of California in Los Angeles in 1971 and M.D. degree from Pennsylvania State University at Hershey in 1975. CAPT Baker was a resident in general surgery from 1975-79 and completed a fellowship in cardiovascular surgery at Baylor College of Medicine in Houston in 1981. He entered the Navy in 1980. He has been a Fellow of the American College of Surgeons since 1985.

CAPT Baker was commanding officer of NR Fleet Hospital Fort Dix, NJ, (1998-2000), executive officer of NR Fleet Hospital 9 in Everett, WA, (1997-1998), director of surgical services for NR Fleet Hospital 21 in Dallas, TX, (1994-1997).

In 1996, CAPT Baker became the first naval reserve officer to head the Medical Civic Assistance Program (MEDCAP) Team for Operation Cobra Gold in Thailand. In 1997 he was part of the first naval unit to visit Cambodia in 22 years as a medical officer of the MEDCAP Team deployed by Naval Special Warfare Group One. He also developed "Medical Response to Operations Other than War," unique training for humanitarian emergencies and disaster relief that has become a template for naval reserve training.

CAPT Baker served with the 1st Medical Battalion during Operations Desert Shield and Storm in 1990-91, and was recalled to the area as Force Surgeon (acting) for Naval Forces Central Command during Operation Southern Watch in 1993. As staff medical officer for NR Naval Forces Central Command he worked on war plans for Persian Gulf contingencies from 1986-1990. He attended the medical management of diving at Panama City Navy Diving and Salvage Training Center, and deployed to the Persian Gulf during the Iran-Iraq tanker war, where he studied and published information on warm water diving which has been included in the United Nations Diving Manual. He was the staff medical officer for Special Boat Unit 11 from 1982-1986, where he earned the "Officer in Charge Combatant Craft, Riverine" insignia (NOBC 9279).

He is Associate Professor of Surgery on the faculty of the Uniformed Services University of the Health Sciences in Bethesda, and consults and teaches for the Center of Excellence in Disaster Management and Humanitarian Assistance at CINCPAC in Honolulu.

CAPT Baker's awards include the Legion of Merit, Meritorious Service Medal, Navy and Marine Corps Commendation (4 awards), Army Commendation Medal, Air Force Commendation Medal, Navy Achievement Medal, Combat Action Ribbon, and Fleet Marine Force Ribbon. He also wears the OIC Combat Craft (Riverine) warfare insignia and the Commanding Officer Ashore Trident Pin. He was awarded the Wellcome Medal and Prize in 1994 by the Association of Military Surgeons of the U.S. for advances in military medicine.

CAPT Robert D. Hufstader, MC, is Commanding Officer of Naval Hospital Pensacola.

CAPT Hufstader enlisted in the U.S. Navy in 1962. As a hospital corpsman he served in San Diego and Japan during the early years of the Vietnam conflict. He attended the University of California, Irvine, graduating in 1970 and entered medical school at the University of California, San Francisco, graduating in 1974 with a Doctor of Medicine degree. He has also earned the degree of Master of Medical Management from Tulane University in New Orleans.

CAPT Hufstader's career as a medical officer began in 1974 with an internship at Naval Hospital, San Diego, and continued with assignments aboard USS *Chicago* (CG-11), Naval Hospital Jacksonville, FL, where he completed family practice residency training, Naval Medical Clinic, Annapolis, MD, and Naval Hospital, Millington, TN.

He then reported to Commander Fleet Activities, Chinhae, Korea, for duty as medical officer, and followed this with an assignment on the USS *New Jersey* (BB-62) as senior medical officer. He returned overseas, reporting as executive officer of U.S. Naval Hospital Guantanamo Bay, Cuba, in 1985. A move to Washington, DC, and assignment as Special Assistant to the Surgeon General in 1987 was followed by assignment as executive officer, Naval Hospital Pensacola, FL, in 1989. In 1991, he reported as commanding officer of U.S. Naval Hospital, Keflavik, Iceland, and in 1994 returned to Washington, DC, as Deputy Chief, Medical Corps, until 1998.

In June 1998, CAPT Hufstader reported as commanding officer of Naval Hospital, Pensacola.

CAPT Hufstader's awards include the Legion of Merit, Meritorious Service, Navy Commendation, Navy Achievement, and Navy Good Conduct medals as well as Navy unit citation, Navy "E", National Defense, Sea Service Deployment, and Overseas Service ribbons. He is a Fellow of the American Academy of Family Practice, a member of the American College of Physician Executives, and a diplomate of the American Board of Family Practice.

CAPT Nancy J. Lescavage, NC, is Assistant Chief for Health Care Operations, Bureau of Medicine and Surgery, Washington, DC.

CAPT Lescavage is a licensed registered nurse. She received a Baccalaureate Degree in Nursing from the University of Maryland and a Graduate Degree from the University of Pennsylvania's School of Nursing/Wharton School of Business. Her diploma in nursing is from Saint Joseph Hospital School of Nursing in Reading, PA.

CAPT Lescavage's previous assignments include: commanding officer, Naval Hospital Corpus Christi, TX (1997-1999), executive officer, Naval Hospital, Great Lakes, IL (1995-1997). Prior to this assignment, she served as a Congressional Fellow on Capitol Hill in the Office of United States Senator Daniel K. Inouye (D-Hawaii) for 21 months. Her main duties focused on being a liaison with the White House and health care task forces concerning National Health Care Reform issues and becoming an authority on the legislative process and its application to health care.

From August 1989 to March 1993, she was on the staff of the Assistant Secretary of Defense for Health Affairs. As a Senior Health Facilities Planner at the Pentagon, she was responsible for the planning and design of military medical construction projects worldwide. Additionally, she served as a nursing consultant to the Department of Defense on clinical matters and

performed comprehensive health care and cost-benefit analyses in support of DOD initiatives.

Prior to her Department of Defense assignments, she was in charge of the Recruit Medical Clinic at Recruit Training Command, Great Lakes, IL. This clinic was responsible for the medical care of approximately 40,000 recruits annually.

Other assignments include: Medical Clinic, United States Embassy, London, Naval Hospital Philadelphia and the National Naval Medical Center Bethesda, MD. During these assignments, she gained expertise in the specialties of Intensive Care, Coronary Care, Operating Room, Obstetric, Neonatology, Recovery Room, Ambulatory Care, Cardiac Surgery, Internal Medicine and General Surgery.

CAPT Lescavage is the recipient of the Legion of Merit, Defense Meritorious Service Medal, two Navy Meritorious Service Medals, the Navy Commendation Medal, the Tri-Service Achievement Medal, and the Navy Achievement Medal. She is a member of Sigma Theta Tau, AMSUS, the Military Order of the World Wars, the Surface Navy Association, the Naval Institute, and the Navy Club.

CAPT Lewis S. Libby, DC, is Commanding Officer, 4th Dental Battalion, 4th Force Service Support Group, Marietta, GA.

CAPT Libby graduated from Loyola College with a Bachelor of Science degree in 1972. He was commissioned an ensign in the U.S. Naval Reserve in 1973 and completed Officer Indoctrination School at Naval Education and Training Center, Newport, RI, in 1975. He graduated from the University of Maryland School of Dentistry in 1976, and was assigned to active duty at Naval Air Station Key West, FL.

CAPT Libby was released from active duty in June 1978 and entered private practice in Baltimore, MD. He reported to VTU Dental 0614 in May 1979 and was assigned to FTL Dent 106 in October 1979. In 1981 he was assigned to NNDC Bethesda 106 as Training Officer and in 1985 reported to 24th Dental Company Detachment 2 as administration officer and later served as executive officer for 3 years. In 1988 he was reassigned to NAVMEDCOM NATCAPREG 106. In October 1989 CDR Libby was selected as Officer-In-Charge of Detachment 2, 24th Dental Company, Washington, DC. He was assigned to NR BUMED 106 in October 1992 and served as unit administrative officer. CAPT Libby was assigned as Commanding Officer, 14th Dental Company, 4th Dental Battalion, 4th FSSG, headquartered in Fort Dix, NJ, in October 1994. In 1996 CAPT Libby was selected as staff dental officer Naval Reserve Readiness Command Region Six. In 1998 CAPT Libby was assigned as Reserve Staff Dental Officer Headquarters Marine Corps, Washington, DC.

CAPT Libby is a Fellow of the American College of Dentists and a Fellow of the Academy of General Dentistry. He is a member of the American Dental Association and has been active in organized dentistry on the state and local level. CAPT Libby is also a member of many other professional and military associations.

He was selected as 4th Dental Battalion Officer of the Year in 1989 and was selected as the Naval Reserve Dental Officer of the Year in 1990. His decorations include the Meritorious Service Medal, Navy and Marine Corps Commendation Medal (3 awards), Meritorious Unit Commendation, Fleet Marine Force Ribbon, and other awards. ❑

NAMRU-3 and the 1967 Egyptian-Israeli Conflict

CAPT Donald C. Kent, MC, USN (Ret.)

In 1996 Naval Medical Research Unit Number Three (NAMRU-3) celebrated its 50th year anniversary. Having been first established in Egypt in 1946 as the U.S. Typhus Commission by presidential order, it was originally made up of a composite of American and Egyptian scientists and technicians working jointly toward the prevention of a possible post World War II typhus epidemic. Following the War it remained as NAMRU-3 under the auspices of the U.S. Navy to involve research dealing with most of the endemic and nutritional disorders which exist in the Middle East.

During the 55 years of its existence serving as one of the Navy's overseas laboratories, NAMRU-3 has been highly productive in research developments as well as educational opportunities for both American and Egyptian scientists. During that period it has had its good years, but also its difficult ones. The year 1967-1968 was one of these.

Late in 1966, I was serving as Chief of Medicine at Naval Hospital, St. Albans, NY. A change of command was due at NAMRU-3 in Cairo in mid-1967 and I was offered the position, which I gladly accepted. Over the upcoming months I would spend considerable time preparing myself with visits to BUMED, NIH (National Institutes of Health), CDC (Centers for Disease Control), meetings with the Epidemic Diseases Control Board, and reviewing pertinent research related to NAMRU-3's research programs.

During this time troubles were brewing in the Middle East. Despite political problems, research at NAMRU continued through cooperation between the American and Egyptian scientists. However, a short time before the outbreak of the June

Photos courtesy of the author

Entrance to NAMRU-3 Cairo, Egypt 1967.

Six-Day War it was becoming evident that a conflict was to be anticipated, and consequently families of the American NAMRU staff were evacuated and sent to safe-haven in Athens, Greece.

With the eventual outbreak of armed conflict, all Americans in Egypt were grouped together and taken by rail to Alexandria, Egypt and thence by ship to Athens. All Americans, including NAMRU staff, closed up their homes and took with them only what they could carry with them. The homes in which they lived were sealed and put under the protection of the Spanish ambassador, since diplomatic relations had been severed with the United States. Our embassy was then converted to an interest section under Spanish administration.

Upon departure of the American staff, NAMRU was placed under protection of the Egyptian Ministry of Health. Dr. Imam Zagloud, a virologist and Director of the Egyptian Virology Laboratory, was in charge, pending return of the American staff. However, he had previously been an employee at NAMRU in the Virology Department and was well known and liked by the NAMRU Egyptian staff. In the absence of the American staff, the remaining Egyptian researchers continued work on a number of NAMRU research projects.

In the meantime, with NAMRU having been evacuated, my orders were put on hold. When the conflict began, I had been relieved at St. Albans, and several days before the beginning of hostilities, packers had arrived at our quarters at Mitchell Field, Long Island, in the process for our departure for Cairo in mid-June. With orders on hold, household effects were returned to the quarters until some decision could be made as to our eventual next duty station.

After several visits to Washington and conferences with BUPERS and BUMED, it was decided that my travel to Cairo was problematic and that instead I would be ordered to the NAMRU field facility in Addis Ababa, Ethiopia. This would be a permanent change of duty so I could move my family there, begin attempts to secure permission to re-enter Egypt, and thence take over command of the facility. This involved re-packing our household effects into three parcels, one to go to Ethiopia, one to go into permanent storage, and one to go into temporary storage until I was able to secure Egyptian permission to move my family to Cairo. Needless to say, we didn't know how long it would be before we would again see our household effects and our car.

Over the ensuing weeks, I applied to the Egyptian government weekly for entry visa permission, each time receiving negative replies. Finally, on 5 August 1967, we flew to Athens to meet with our evacuated NAMRU families.

During the ensuing weeks I had to make decisions regarding plans for NAMRU staff members. At that point, we had no idea when Egypt would allow any of us to re-enter, and calculated it would probably be many months for most of them. On this supposition, some were returned to CONUS for reassignment, some were returned to CONUS to other Navy activities to await return to NAMRU, a few were reassigned to the field facility in Ethiopia. A few, particularly administrative staff, were to remain in Athens to carry out NAMRU administrative duties. Army, Air Force, and U.S. Public Health Service personnel returned to their parent services for reassignment. A few researchers remained in Greece, and I was able to find them Greek research facilities in which to work while awaiting return to Cairo.

Upon completing these administrative matters, we proceeded to Addis Ababa. Settling there involved getting my family into proper quarters and acquainting myself with the research program at the field facility. As I noted previously, each week requests for an Egyptian entry visa were made in Addis Ababa, Athens, and Washington; each met with a negative reply.

Having no word as to what was happening in Cairo, and anxious to get there and resume operation of the facility, I decided to proceed to Cairo with no entry visa in hand, flying from Addis Ababa via Ethiopian Airlines. This was rather difficult because, under usual circumstances, one required an Egyptian visa to board a flight in Addis Ababa. However, the station manager of Ethiopian Airlines in Addis Ababa was an American TWA employee who happened to be a commander in the Naval Reserve. He got me on the flight without the required visa. On an early morning in September, I boarded a flight to Cairo, accompanied by Dr. Harry Hoogstraal, a long-term NAMRU scientist, who had spent some 15 plus years as head of the Department of Zoology. He was a long time friend of Egypt and a world-renowned expert in entomology and tick-borne diseases.

We arrived in Cairo late afternoon and remained in the waiting area since we had no entry visas. We were able to get word to Abdel Azis Saleh, the Egyptian administrative assistant to the commanding officer, that we were at the airport. Through his connections with the Egyptian For-

eign Office he was able to get us one-time entry visas. And so we were back in Cairo.

The next morning we had a change of command at NAMRU in which I relieved CAPT Lloyd Miller. He was on his way back to Washington to assume charge of the Research Division in BUMED. It was a very happy day for me. At last I had assumed command despite the fact that I had no American staff other than Dr. Hoogstraal. My researchers were all Egyptians, none whom I knew, my American staff was scattered, for how long I did not know, and my administrative staff was across the Mediterranean in Athens, out of direct contact. There was no U.S. ambassador, we had no diplomatic immunity, and my task to rebuild NAMRU lay ahead.

The first night Dr. Hoogstraal and I hosted a dinner party on the roof of the Semiramis Hotel in downtown Cairo for a number of our senior staff and their wives. The favorable response that followed was particularly gratifying. The next day we had dozens of telephone calls from Egyptians welcoming us back to Cairo and wishing us well. I knew that my stay was going to be successful.

My first job was to check the equipment present in NAMRU against a list of what was known to be there when the American staff left. Everything was there and intact, with the exception of a single 15-year-old typewriter that was probably lost sometime earlier. The Egyptian staff had taken wonderful care of our Navy property, which included substantial and expensive research equipment.

Even more gratifying was the wonderful news that our Egyptian research staff had carried on with a number of ongoing projects. Mountains of data, reference materials, and a research library were completely intact. Manuscripts were continuing to be prepared.

A large animal colony was also intact and healthy, having been maintained with proper diets despite the difficult days from June through September.

Egyptian staff attending NAMRU change of command.

After becoming familiar with the talents of the Egyptian personnel, my next task was to redevelop NAMRU's research programs to accomplish BUMED's goals as well as the needs of the Egyptian government. Because of the Egyptian staff's breadth of training and experience, this did not require varying what had been underway when the American personnel had evacuated. So we proceeded to forge ahead, awaiting at some future date a return of our American colleagues.

Next I set out to take care of household effects and automobiles belonging to the Americans who had gone back to CONUS, never to return. Those coming to Cairo would live in individual houses, and thus had to bring household appliances compatible with Egyptian electric current but not suitable for use back in the U.S. Likewise, those who had already departed had automobiles especially procured for use in Egypt, with plans to sell them when they departed Egypt. All these vehicles remained behind.

We therefore inventoried all the abandoned possessions remaining in the now unoccupied homes and communicated with the owners as to whether they wished items to be shipped or sold in Egypt. Entering those dwellings required getting permission from the Egyptian government to sell the items if requested. We then had to prepare the remainder of their household effects for return to CONUS. All this was accomplished with no administrative staff, and with minimal help from the interest section which now consisted of only 12 State Department members.

Most former staff members wanted their major items sold. I became a

Ward Rounds, Schistosomiasis Ward, NAMRU, 1968. VADM George Davis (left), Surgeon General, Dr. Zohair Farid, Admiral R. Rafetto, and Admiral Ralph Faucett, Assistant Chief for Research and Medical Specialties.

middleman, selling items to the highest bidder, but only selling if I could get at least the minimum amount requested by the member. Needless to say, this process occupied most of my time during my early weeks in Cairo.

During this time, research projects were being developed, and already existing ones completed. NAMRU was able to fulfill its mission only with the constant cooperation of Egyptian officials, especially those of the Ministry of Health. And it was the existence of a firm, loyal group of Egyptian scientists and technicians working within NAMRU that provided for continuity and cooperative research.

Over the ensuing months, we were finally able to get Egyptian permission to re-admit key members of NAMRU's staff. The first was my administrative officer, followed by the executive officer and senior pathologist. Over subsequent months other key personnel returned. I was finally able to secure a visa with re-entry permission after 4 months and returned to Addis Ababa to see my family. I had left 4 months before, expecting to be back in a few days. As American staff members returned, we set up each department to be managed by two members, one American and one Egyptian in case diplomatic problems again required the Americans' departure.

We set up a bachelor quarters, so unmarried members no longer had to acquire extensive household equipment to set up living arrangements. In July 1968 I was able to move my family to Cairo.

We all lived through the turmoil of the Six-Day War and its aftermath, and NAMRU has continued to remain productive ever since. Despite the crisis and tense relations between the Egyptian and U.S. governments, Egypt remained friendly to all who served there. Even today, NAMRU and Cairo remain high on everyone's list of favorite and special duty stations. ❑

Dr. Kent is a consultant to Pfizer World Research and Lawrence and Memorial Hospital, Groton, CT.

In the March-April 2001 issue the following information was omitted in error: James R. Armstrong, RN, BSN, CCRN, author of Philadelphia, Nurses and the Spanish Influenza Pandemic of 1918 is a Lieutenant Commander in the Navy Nurse Corps Reserve. He drills with Fleet Hospital, Fort Dix, NJ.

“Navy Medicine at Normandy” Release

Photos by John Lewin

D-Day veteran Dr. Lee Parker and Navy Medical Department Historian Jan K. Herman pay their respects at Normandy’s American Cemetery.

Eleven and a half minutes into the film, "Saving Private Ryan," a demolitions man shouts for Captain Miller, played by Tom Hanks, to get out of the way. In the midst of slaughter and chaos, the man and his comrades are about to demolish some nearby obstacles to create a path for the tanks to come ashore. Most viewers would not have recognized the red rainbow on the man's helmet identifying him as a member of a Naval Beach Battalion.

A popular misconception exists that once the Navy accomplished its mission of transporting the armies to France, and bombarding the German defenses with naval gunfire, the ships returned to England. In fact, it was the men of the Naval Beach Battalions—the so-called "sailors dressed like soldiers"—who cleared the obstacles, "directed traffic," set up communications with ships offshore, and repaired damaged landing craft. Beach Battalion physicians and hospital corpsmen had the unique responsibility of treating casualties where they were hit and getting them evacuated off the beach aboard the now empty landing craft. (*Navy Medicine*, November-December 2000.)

Director Jack Lewin of the Naval School of Health Sciences checks sound levels during the shoot on Omaha Beach (*above*) and directs Jan K. Herman and cameraman Wayne Paull in a German bunker at Normandy's Pointe du Hoc (*left*).

The soon to be released hour-long video, "Navy Medicine at Normandy," in the Bureau of Medicine and Surgery's seven-part series, *Navy Medicine at War*, not only tells the story of these unsung heroes, but also highlights the vital role Navy medical personnel played aboard LSTs that received the wounded offshore, and in medical facilities back in England.

You may order "Navy Medicine at Normandy," by contacting Mr. Jack Lewin at email: jmlewin@nsh10.med.navy.mil. Use Normandy in the subject line.

Patient and Rescuer

John F. Fenwick, Jr.

SGT John F. Fenwick, Jr. is lucky to be alive. It was a misty morning in October 1951 when his patrol, on a mission to capture a prisoner to interrogate, accidently collided with a superior force of North Koreans. Most of his Marine comrades perished in the savage firefight that followed. The exchange left Fenwick bleeding and near death as at least four machine gun bullets ripped through his body. As a hospital corpsman pulled him to safety, he too was severely wounded. Despite his own injuries, he did what corpsmen are trained to do—protect their patient, administer first aid, and see the wounded Marine safely to the rear. The story does not end there. It took a skilled Navy surgeon and his team many hours to repair the damage and put SGT Fenwick on the long road to recovery. He recalls that unforgettable time nearly 50 years ago when Navy medicine came to his rescue.—Ed.

It was 5 October '51. I'll never forget it. I was a machine gun squad leader in Co. A, 1st Battalion, 5th Marines. The captain called us in and told us he wanted a prisoner to interrogate. He told me that I was short and would be relieved in 2 days, and then would probably be going home. He then said I didn't have to go on this patrol. We had a brand new green lieutenant who had only been with us 2 days. I figured I had better go because he'd need some advice. A good officer will listen to his NCOs who had some combat experience.

SGT Fenwick recovers from his wounds at the National Naval Medical Center.

We were northeast of Inje, close enough to the ocean to have naval gunfire from the battleship *Missouri* supporting us. We went out before dawn. The lieutenant disobeyed orders and got us all fouled up. We ended up in the enemy lines. You could hear them talking and starting their cooking fires. It was scary as hell. We then pulled off that hill and instead of going right back to our lines and taking advantage of the heavy ground mist, the lieutenant said, "Let's try that other hill." The platoon sergeant who outranked me kept telling him we had to get back to our lines. "You can't make a name for yourself out here because you're gonna get everybody killed," he said.

The mist burned off and we were exposed out there, almost like someone had turned on a light switch. Then one shot rang out. Lyons, a friend of mine, was at the point and got one right between the eyes. We were only 50 yards from some of their bunkers, maybe even closer than that.

We ran behind a nearby knoll but they continued to fire at us from two sides and the front. We got the machine gun set up on the knoll and began to answer fire. But it was like taking a motorcycle and running up against a tractor trailer. We had literally hundreds of them shooting at us. The whole platoon got shot to pieces. The lieutenant then called in supporting artillery and when they registered in, the shells landed right on top of us on that hill. I guess he fouled that up too. Finally, they corrected, and the shells began landing on enemy lines.

By then, just about all of us were hit. Our machine gun was out of ammunition and was knocked out. I was the last guy alive on that knoll. I saw some of the enemy trying to work their way around our right and get behind the hill where all our wounded were. Our corpsman, Glen Snowden, was treating the wounded below. So I grabbed an M1 off the dead kid who was lying beside me and I raised myself up to shoot at the infiltrators trying to outflank us. That's when I got it—four hits in the body—machine gun bullets. We were so close I could feel the muzzle blasts. It was a Russian light machine gun. When you were in Korea awhile you could tell every weapon firing at you.

It's indescribable the way it felt. It was like being run over by a train. I was bent backwards. It turned out that two of the bullets grazed my spine. I could feel everything else except for my legs. It was horrible pain.

Doc Snowden came running up and grabbed me. He checked everyone else real quick but saw that everybody else up there was dead. He said, "I've gotcha; I'll get you

out of here." As he started pulling me, the machine gun got him twice in his left shoulder and knocked him right down the hill. He scrambled right back up again. One arm was hanging down and useless but he still grabbed me and got me out of the line of fire.

He began telling the unwounded riflemen how to dress guys' wounds. I had an artery severed on my left flank, and the exit wound in my back was the size of a fist. Apparently the bullets had hit my ammo belt and tumbled. Some hit my small intestine and I eventually lost 18 feet of my small intestine, which is nothing. If they had hit my large intestine, that would have really been bad.

Snowden dragged me out of there with one hand. When I finally got back to our lines I told the guys to write him up for a Silver Star, at least. He saved a lot of guys besides me. He grabbed a jacket off one of the dead Marines and rolled it up into a ball. He was all out of battle dressings. He then put it against that hole in my back and took another jacket and tied it around me real tight, like a compress, to stop the flow of blood. And that's what saved me. He had some morphine syrettes left, and told a BAR (Browning Automatic Rifle) man, [CPL Richard]Baiocchi to give me some morphine. Baiocchi then said, "Here, I'll give you some morphine." He stuck the morphine syrette in my shoulder. I was looking into his face and saying "Thank you, pal," or something like that, and just then a machine gun burst hit him right in the jaw and sheared it off. His whole chin was gone. He also took six rounds between his wrist and elbow.

Unfortunately, I didn't get the morphine because as he got hit, the impact snapped the needle off while it was still in my arm. The pain was unbelievable. It was like someone had opened me up with a scalpel without any anesthetic and then filled up my insides with red hot embers. I forgot to mention that when Doc Snowden grabbed me, two more bullets got me in my left upper arm. One was a graze and the other went through the flesh real quick.

After Snowden got through with me, two Marines grabbed each of my feet and dragged me face-down back through the rice paddies. They were under such fire that they had to run, dragging me on my face through all that muck. It's a wonder I didn't drown.

When we got back a ways they put me on a litter. I really thought I had died because when we got halfway back, I felt warm and peaceful. All the pain left me. While I lay face down on the stretcher, I saw a real bright orange hazy light but there was no pain. I remember thinking, "Thank God, it's all over."

Right about then there was an air strike on the enemy position and that pulled me out of it. It really made me feel good thinking that the ones who got me were getting fried with napalm.

When we got back to our own lines I was still conscious. A helicopter landing pad had been dug out on the reverse slope of a hill. They didn't think I was going to make it. Only one chopper could be brought in there at a time, and there was only room for two wounded on each. There were so many wounded, they could only take the ones who had a chance of making it. Some of them went down the hill on stretchers.

A chief corpsman told one of the surgeons to look at me. I remember he had a big walrus moustache. "Sir, you had better look at this man. It looks like his color's still good." The doctor then said, "Take one of them out of the basket and put him in." The other guy was a rifleman from Texas. He had four bullet wounds stitched across his chest. He was in one basket and I was in the other. He didn't make it. And he had three kids at home.

They flew us back to Easy Med. I remember being very scared. They put me on a slanted wooden table and cut all my clothes off. Then they put a catheter in my penis. The surgeon's name was [LTJG Howard] Sirak. He really put me at ease. And then with his finger he drew a line on my stomach and said they were going to make a small incision. That was no small incision. They ended up cracking me open—a laparotomy! Dr. Sirak later told me they put 837 sutures in me. Rather than making a colostomy, they kept snipping perforated small intestine off and re-sewing [the ends] together.

When I woke up, it was night. I only saw one Coleman lantern at one end of the tent. I was lying on the cot and felt all warm and sticky on one side. I had dysentery once and thought I had messed myself. I called a corpsman who came to me with the lantern. He said, "Don't worry, it's just blood." I had blood and plasma going in both feet and both arms—IVs. There was a catheter tube coming out of my nose, another tube in my penis, and another coming from the exit wound in my back.

The next morning both surgeons and Doc Snowden came in. He was all patched up with his arm in a sling. They told me they had to get me up on my feet. I said, "You've gotta be kidding me. I'm dyin' here. I can't feel my legs; I can't move. He said, "When we got in there we found three vertebrae that were just grazed by the bullets and were fractured. But you have what they call spinal shock. The feeling will return. We can practically guarantee it."

But I was really worried I was going to be a paraplegic. But for the grace of God, another eighth of an inch, I would have been. The bullets had tumbled their way through me. Then I got peritonitis real bad. I remember by the time I got to the hospital ship I was getting 500cc's of penicillin a day. It could have been fragments of filthy clothing going through with the bullets, or stuff from the rice paddy, and of course perforated intestines. I remember the day I got hit I hadn't had anything to eat, just a sip of water. The surgeon said that had I had food in my intestines, that probably would have been it. I wouldn't have survived.

From there they sent us to the hospital ship—the *Consolation*. They put us in slings and hoisted us aboard. It looked great. It was snow white—unbelievable! The ward was so clean and beautiful. I think it was even air-conditioned. I didn't want to get in that bunk. It was so clean and I was so filthy. There was all the crud from the front plus blood caked all over me. I hadn't been in a bed in over a year. When they got me all cleaned up and in a bunk, gave me all my shots, and changed my dressings, the nurse, a lieutenant commander, said, "How would you like to have some ice cream?" I couldn't believe it. I thought, I'll really fool her. So I said, "Yeah, I'd love to have some." And she said, "What flavor?" And knowing they wouldn't have it, I said, "Rocky fudge." And then she said, "Coming right up, Sarge." Then I completely lost it. I grabbed her hand and kissed it. Then I broke down crying. "You Navy nurses are really angels of mercy."

SGT Fenwick incurred six machine gun bullet wounds. Two were through and through wounds of the left upper arm with no permanent bone, muscle, or nerve damage. Four were through and through wounds of the left flank, involving the small intestine, left pelvis, left iliac crest and iliac joint, which was destroyed by direct trauma. There was a large exit wound in the lower, left back adherent to the lumbar spine with fractures of L-3, L-4, and L-5. The left artery was severed. Two of the gunshot wounds were "keyhole" rounds, which tumbled, causing large muscle and tissue damage and loss in the lumbar spine region. After a long hospitalization, he was declared permanently disabled, and was discharged from the Marine Corps in 1954. He currently resides in Delaware. When asked about his care then and since, he says, "I told my wife that if anything happens to me, the hell with these civilian or VA hospitals. Get me over to Bethesda [National Naval Medical Center]. I have the highest regard in the world for Navy medicine." ❑

During his long convalescence at NNMC, SGT Fenwick penned some of the drawings accompanying this article. Fifteen years later he produced the rest.


USMC
"CORPSMAN"!..."DOC"!
JLF


USMC
OH GOD – GIVE ME TOMORROW"
JCF
1967


"COMMUNIST MERCY"
AMBUSHED FIELD AMBULANCE - ALL WO
SLAIN - DEC. 1950 - ON THE ROAD JUST NORT
OF HAGARU-RI, CHOSIN RESERVOIR CAMPAI


USN

On 26 October 2000, Navy Medicine *interviewed former hospital corpsman HM3 Glen C. Snowden, Co. A, 1st Battalion, 5th Marines, 1st Marine Division, about his rescue and treatment of SGT John Fenwick.*

What do you remember about October 5th, 1951, the day you and a whole bunch of other people got pretty badly hurt? Do you remember a Marine named Fenwick who was very badly wounded that day? He was hit in the stomach. He remembers you trying to drag him out of the line of fire while the North Koreans were shooting at the both of you. He also recalls that you were shot in the arm and tumbled down the hill. But that you got right back up again and dragged him the rest of the way to safety.

I remember that. I had to get him up over the hill because he had slid down on the enemy side. If we stayed there we'd both have been shot. So I grabbed him by the ankles and told him, "Put your arms on your stomach and hold them down real good." And then I said, "I'm gonna pull you up." He said, "No. I don't think I can make it." And I told him, "You're gonna make it because I'm going to start pullin' right now." I tied his hands together and put both my hands underneath his armpits as far as I could. Then I got his head up on my chest, and started moving. I wanted his head up high where I could see whether he was breathing or not. You don't want [your patient] to bleed from the mouth. If they do, they can choke. And that's the way I pulled him back up. The only thing that stayed on the ground as I pulled him were his heels.

And you were already wounded yourself at the time.

Oh, yes, but I wasn't bleeding. I had already plugged that up. I put a peg in it.

You did what?

I pegged it.

What do you mean you pegged it?

I'd take a limb and kind of smooth it with my knife. Then I'd break it off. I'd make a couple of them and put them in my pocket. Then if I got shot, I'd just stick one in the wound real fast.

Like a cork?

Yes. And it wouldn't bleed. You'd be surprised how that worked.

I've never heard of that before.

So I got him up there [on the back side of the hill], and the first thing I had to do was bandage him. I tore his shirt in the back where the bullets had come out and patched him up there. I put a great big [battle dressing] on him and tied it as tight as I could get it. And then I turned him over and patched up his stomach. That's when the corpsmen started yelling that they had a vacant litter. We grabbed him underneath the arms and put him on that litter and they took off. I yelled, "Good bye. You're goin' back to the states. I wish you all the luck in the world. I know you're goin' to make it back, so take it easy." And he waved at me.

Did you ever find out what happened to him after he left?

I never found out. I called after I got back down to the base but they must already have taken him. I guess they put him right on that hospital ship.

When I called you yesterday and told you I had talked to Mr. Fenwick, and he was very happy you had saved his life, was that the first time you even knew he was still alive?

Yes. That's the first time. As long as I was over in Korea, nobody would send any information through on the radio telling me what happened to him.

Well, Mr. Fenwick is okay thanks to you and wants to say thank you.

I appreciate what he said. I guess I probably saved quite a few lives over there, but I sure put everything in it when I saved him. ❑

Glen Snowden, who is also a World War II veteran, resides in Houston, TX.

Disaster Relief and the Navy Entomologist

LCDR David M. Claborn, MSC, USN

An often-forgotten consequence of natural and man-made disasters is a subsequent increase in the risk of vector-borne diseases. Major disasters destroy housing and water containment systems that normally protect people from mosquitoes, flies, and vermin. As a result, survivors must cope with swarms of insects and rodents that thrive in a soup of waste water, unburied garbage, and the carcasses of man and animals. Communities recovering from hurricanes, earthquakes, floods, and wars must also deal with accompanying epidemics of malaria, dengue, cholera, and other diseases. Unfortunately, local governments often lack the capability to respond adequately to the need of the stricken populations because vector control services may have been destroyed by the disaster, if they ever existed at all. In such situations, local officials need access to expert consultation, insect surveillance, public education expertise, and effective vector control. Rarely are all of these capabilities available from one source.

Over the last several years, the Navy has developed the ability to respond with a more comprehensive array of weapons in the fight against vector-borne disease following disasters. More importantly, Navy entomologists continue to seek ways of improving disaster relief efforts not only with advice and consultation, but also with meaningful capacities to change the disease environment through effective vector control.

Surveillance efforts following natural disasters

Some of the earlier disaster relief efforts by Navy entomologists were necessarily limited to surveys of disaster damage and consultation with local public health officials. One example is provided by entomological support after Hurricane David in the Dominican Republic. That storm caused an estimated 1,000-1,500 deaths and injured nearly 4,000 people. The Navy helped survey the storm damage and provided an assessment of vector-borne disease. As a direct result of after-action reports from Hurricane David, the public health community became more aware of the potential for disastrous disease outbreaks after natural disasters. As would be seen with later efforts at humanitarian assistance, logistical impediments and poor transportation limited the Navy's ability to control the vector populations in the Dominican Republic.

Later storms, however, demonstrated that insect surveillance alone can be tremendously beneficial in the months immediately after a disaster. Following the Midwest floods of 1993, for example, a team of Navy entomologists responded to a request for assistance from the state of Missouri. Extensive mosquito surveillance was used to evaluate the risk of St. Louis and Western equine encephalitis to local inhabitants. Over 250,000 mosquitoes were trapped, identified, and analyzed during this study, which eventually concluded that risk to humans was very low. One tangible benefit of the surveillance program was that Missouri decided to forego a proposed mosquito control program that would have blanketed the area with insecticides at a cost of nearly $20 million dollars. The surveillance program cost only $100,000, but it allowed public health officials to make an informed decision that saved money and

reduced the chances for further environmental disruption, all without increasing the risk of disease to human inhabitants.

Similar surveillance and consultations have been performed for outbreaks of disease. In 1993, Navy entomologists were part of a team that investigated an epidemic of Rift Valley fever at the request of the Egyptian Ministry of Health. In 1995, the Navy consulted with public health officials on the island of Palau during an epidemic of dengue. Even Vietnam has benefited from recent Navy efforts in malaria control. These efforts were instrumental in identifying the disease vectors and providing advice on how to disrupt the disease cycle, but they did not get directly involved in vector control. Other disasters, however, provided ample opportunities for vector control.

Photo courtesy of author

Helicopter flown by local pilots damaged during aerial spray operations in Maracay, Venezuela in 1990. Fortunately, no one was seriously injured.

Vector Control Efforts

Vector control capabilities in the Navy are concentrated in two units called Disease Vector Ecology and Control Centers (DVECCs)—one in Jacksonville, FL, and the other in Bangor, WA. Manned primarily by commissioned entomologists and preventive medicine technicians, these units serve as training, testing, and operational centers for most aspects of vector control that are required by the Navy and Marine Corps. In addition, a complete inventory of insecticide dispersal equipment is maintained at these centers for contingency uses like wartime vector control and humanitarian assistance. Equipment ranges from backpack sprayers to trailer-mounted turbines capable of spraying a stream of liquid insecticide dozens of feet into the air. The units even maintain aerial spray equipment for use in helicopters. All of this equipment has been used for disaster relief in the last 10 years.

One of the biggest responses was after Hurricane Hugo when three teams of entomologists and technicians deployed to Puerto Rico, St. Croix and Charleston, SC. These teams performed numerous tasks, from surveillance to fly and mosquito control. These areas had experienced outbreaks of dengue and eastern equine encephalitis just prior to the hurricane, so the possibility of increased disease risk was very real. Hurricane Hugo served as a harbinger of several other tropical storms to which the Navy responded.

Most recently, several entomologists were involved in disaster relief after the enormous destruction of Hurricane Mitch in Central America. This last deployment reflected one of the recurrent problems with disaster relief efforts: reliable transportation. Because the teams must travel lightly in order to obtain flights into disaster zones, entomologists must often rely on either local transportation or on vehicles provided by other military units. This reliance results not only in inconsistent transportation, but also in some danger.

That danger was best demonstrated in 1990, when two vector control teams went to Venezuela at the request of the Pan American Health Organization. The teams established aerial spray programs to control mosquitoes during an epidemic of dengue hemorrhagic fever. One of the helicopters, flown by local pilots, crashed after hitting a high-tension power line. Amazingly, no one was seriously injured, although the two Navy entomologists on board were kept in the hospital overnight for observation.

The incident emphasized the extraordinary care required to work in areas where traffic laws, equipment maintenance, driver training, and other aspects of public safety are different from those in the U.S. Unfortunately, the situation often dictates that disaster relief workers rely on vehicles in short supply driven by reckless local drivers on crowded roads that are severely damaged by the disaster. Great care must be taken to ensure the health and well-being of relief workers so that they do not become victims of the disaster themselves.

Public Education and Vector-borne Disease

A common concern for many disaster relief workers, including entomologists, is the temporary nature of their efforts. Vector control during an epidemic may mitigate the immediate situation without addressing the underlying factors leading to the outbreak. In other words, how much real benefit do relief efforts really provide? One approach to reducing the need for

emergency relief is to develop more self-sufficiency in local communities that are prone to disruption. This goal can be obtained with simple technologies like insecticide-treated mosquito nets and sanitation to reduce the number of larval breeding sites. The Navy has participated in two Army efforts to accomplish these long-term goals in Haiti and Jamaica with the hope of establishing a continuing education program in vector control for public health in these countries.

One unique aspect of such training was the added goal of developing environmentally friendly techniques to replace others that may be more disruptive, such as the use of sanitation to reduce mosquito numbers rather than the common practice of using extremely toxic agricultural chemicals in local public health initiatives.

Entomological support by Navy personnel after disasters now includes a more complete spectrum of appropriate responses, including surveillance, public education, expert consultation, and operational vector control. Because the Navy can respond quickly with such expertise, entomologists have deployed numerous times in the last 20 years to provide relief from epidemics, zoonotics, and disasters, both man-made and natural. Table 1 is a partial list of such deployments since 1979.

It should be noted that the primary mission of the Navy entomological community is to support the Navy and Marine Corps in issues of public health and pest control. In that role, they may accompany Marines and Sailors throughout the world, providing vector control and expert advice. They also provide pest control and environmental expertise to existing military bases and they conduct research on medically important insects in the overseas research laboratories of Egypt, Indonesia, and Peru. However, the increasing use of the American military in operations other than war has dictated the development of "one-stop-shopping" for matters involving vector-borne diseases in disaster relief operations. The Navy is not unique in having developed a complete spectrum of responses to such scenarios; other military and civilian organizations can respond with similar capabilities. The degree to which these capabilities will be maintained, improved, or even utilized will depend on future political and organizational support, as well as the need generated by future disasters.

Dr. Claborn is assigned to the Department of Preventive Medicine and Biometry, Uniformed Services University of the Health Sciences, Bethesda, MD.

Table 1. U.S. Navy entomological support to civilian organizations (1979 to 1998)

Year	Supported Group	Reason for support
1979	Dominican Republic	Hurricane David
1986	San Diego County Public Health Dept.	Autochthonous malaria outbreak
1989	California Public Health Dept.	Zoonotic outbreak of plague
1989	St. Croix	Hurricane Hugo
1990	Venezuelan Ministry of Health	Dengue hemorrhagic fever
1991	Department of Energy	Resettlement of Marshall Islands
1991	Bangladesh	Typhoon
1991	Haitian refugees	Refugee interdiction
1993	Egyptian Ministry of Health	Rift Valley fever outbreak
1993	State of Missouri	Floods
1993	U.S. Public Health Service	Hurricane Andrew
1993	People's Republic of Vietnam	Malaria epidemic
1995	Centers for Disease Control & Prevention	Hantavirus pulmonary syndrome
1995	Cuban refugees	Refugee interdiction
1995	Palau	Dengue outbreak
1996	Haiti	Public education
1996	Jamaica	Public education
1998	Puerto Rico	Hurricane Georges
1998	Guatemala	Hurricane Mitch
1998	Nicaragua	Hurricane Mitch

The name Joel T. Boone is legendary in the Navy Medical Department. By the time he retired from government service in 1955, VADM Boone had earned the Medal of Honor for valor on the Western Front during World War I, was White House physician for three presidents, and served on ADM William Halsey's staff as Third Fleet medical officer during World War II. Following Japan's capitulation, Boone was the first Navy physician to enter Japanese prisoner of war camps with orders to liberate Allied survivors. Even today, Dr. Boone remains the Navy's most decorated medical officer.

Photos from BUMED Archives

Birth of the Helo Deck

VADM Joel T. Boone, MC, USN

In September 1950, following the successful Inchon operation, Dr. Boone, accompanied by an aide and long time associate, CDR Allen Bigelow, MSC, went to Korea to assess the state of Navy medicine's support of U.N. operations. After a good night's sleep aboard the USS **Rochester** *(CA-124), Boone went ashore to find Inchon virtually destroyed. He was also shocked to find tremendous numbers of wounded, mostly Korean civilians and defeated North Korean soldiers. To Boone's practiced eye, what seemed most lacking was a quick and efficient evacuation system that could move casualties from where they were injured to advanced medical care in the shortest possible time. The presence at Inchon of the hospital ship USS* **Consolation** *(AH-15) was comforting, but getting patients aboard was problematic. Because of a continuing enemy presence, the white ship had to remain out of artillery range and a bit too far from where she was most needed. Dr. Boone tells the story of how all that changed.*

Enemy wounded and the wounded of our American forces were brought to the beach landing area in Inchon. The roads were becoming very heavily congested with various forms of transportation hurrying in both directions. There were many, many wounded being conveyed to the landing down on the waterfront.

I recognized that the progress of evacuating wounded was very retarded under such circumstances. If relief was not forthcoming expeditiously, many of the wounded would die who had a chance to live otherwise, and the wounded conditions would be aggravated. I knew something had to be done to speed up evacuation of casualties, both American and the enemy—North Koreans. Also a multitude of civilians had been wounded, and relief should be effected for them as quickly as possible.

Bigelow and I returned to the *Rochester* in mid afternoon of September 18. I told [VADM Arthur D.] Struble* of my observations and deep concern. I observed that the hospital ship *Consolation* was too far removed from beach landings. He said they were about six miles down the bay and could not be brought up closer because the firing at night on our ships was so intense that we might lose the only hospital ship we had there (the *Consolation*) and then be without any. I told Struble that I wished to visit the *Consolation* and inquired how I could get aboard her, except at the expense of a great deal of time.

He said that he could loan me his fastest boat, which would take from an hour to an hour and a half to go from the *Rochester* to the *Consolation*. I knew I would need about an hour aboard the hospital ship to see the patients and confer with the commanding officers, that is, of the ship and of the hospital part of the ship. I did not see how I could make the round trip and accomplish my mission in less than three hours.

It was almost mid afternoon when he and I were having our conference about my trip to the hospital ship. Struble said that would bring me back to the *Rochester*, with exposure to possible fire, after sundown, and no boats were allowed to be underway in Inchon waters after sundown. He did not believe the trip could be made under those conditions as enumerated.

I asked him if there weren't some other way for me to get to the hospital ship. For example, did he have a helicopter aboard. Struble looked very surprised and said, "Why, yes, I have one on the fantail of the ship." I asked if I could talk to his pilot. He said, "Certainly," so he sent for his pilot and I talked to him in Struble's cabin. I asked the pilot if he were willing to fly me down to the hospital ship, and he said he certainly would, but I had to remember that there were no land-

*Struble was Commander, 7th Fleet.

HO3S helicopter aboard *Consolation's* new helo deck.

ing facilities on the hospital ship; however, he said I could be lowered from the fuselage of the helicopter by a steel guide wire using a controlled hydraulic pulley. I said it would be a novel trip for me but prove of much value, I was sure.

I told Al Bigelow he did not have to accompany me if he didn't wish to do so; but, if he did, it would require two trips of the helicopter from the *Rochester* to the hospital ship and return, because the helicopter only carried a pilot and places for two passengers in the cockpit. A mechanic had to make the trip with us, handling the lowering and hoisting lines for whoever would make the landing and be returned to the helicopter. It was arranged that I would fly first with the pilot and the mechanic, and on a subsequent trip Bigelow would do likewise.

After taking off from the deck of the *Rochester*, we flew toward the *Consolation* and circled it from about 300 feet elevation. Due to the masts, the guy lines, antennas, stack, etc., it would appear there would be no place where a passenger could be landed. Looking down, I spotted what I felt was a large enough space near the deckhouse on the fantail. The pilot felt sure he could land me there so he instructed me what to do.

The mechanic and I were sitting on a seat just behind the pilot. A canvas strap was handed to me which I placed under my arms and which was attached by a snaffle to the arm of a sling and then was swung out from the helicopter's doorway. There was no closed door. Having done this, I so reported to the pilot. He said, "Now take a hold of a rod on the back of my seat and have one of your feet find a rod underneath my seat. Hold firmly to the rod on the back of the seat and with your foot reach out the doorway and you will find a rod underneath the doorway on which you place your foot."

Having done this, I reported to the pilot that I was holding on to the rod back of his seat and my foot was on the rod under the doorway. He said, "Now release yourself from holding on to my seat and keep your foot on the rod outside the door, and the metal line will be swung out, held tight by a hydraulic control; then take your foot off the rod outside of the doorway." I said, "And then what?" He said, "Then you float into space," and I was aware: "That's when you really get your thrill."

Before I left the cockpit, I was told to put on a life preserver and a "Mae West," named for the well known bebosomed actress, which would be inflated in case I would be dropped into the water.

As I was swinging around in my descent from the cockpit of the helicopter to the deck of the *Consolation*, I felt like the man on the flying trapeze and thought of my wife and what her comments would be on my undertaking such an expedition. I thought she would be thinking to herself, "What a fool her old admiral husband was to undertake such a mission."

There was great excitement at seeing my arrival. Many cameras appeared, as they wanted to see this undertaking I had embarked upon. I was pleasantly greeted, escorted to the sick quarters to see patients. I knew time was a very important factor, so I did not delay too long over beyond what I thought would be necessary to accomplish my mission. I saw most of the patients and talked to many of the staff members in addition to the commanding officer of the ship and the commanding officer of the hospital part of the ship.* In returning to the place on which I had landed on the deck, I signaled to the helicopter pilot to pick me up. He sent down on the guide line a life preserver and a Mae West. These I put on and signaled that I was ready to be hoisted aboard. As I was hoisted from the deck and came nearer and nearer to the helicopter, I naturally, because of my weight, spun faster and faster, and, when I was hauled up near the door I had to, as I had been instructed, make a grab for the door frame and pull myself into the cockpit. I missed the doorway by not being able to grab it three times before I successfully got myself into the cockpit area. It was a big relief to be safely back in the cockpit.

Before leaving the hospital ship, Captain [Robert E.]Baker, the commanding officer of the hospital part of the ship, asked me to fly over and around the ship before I departed toward the *Rochester*, so that they could get pictures of me in flight. This we did, and then made our successful flight [back] with a feeling of relief that our mission had been successfully accomplished.

Admiral Struble and, I think, most all officers and many of the members of the crew were out to see this expedition return. I thought [they] were apprehensive that we would not safely return.

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*Following Boone's visit, CAPT Baker sent a report to Surgeon General of the Navy RADM H. Lamont Pugh. "18 September 1950. Admiral Boone and Commander Bigelow came aboard via helicopter for a short visit and Admiral Boone stated that he would try and arrange for us to move (the hospital ship *Consolation*) closer to the beach since the long boat ride was believed to be detrimental to the patients' welfare. On 21 September our anchorage was shifted to a position off Wolmi Do Island, providing a much shorter boat ride for casualties."

Having been greeted by Admiral Struble, I asked if I could come into his cabin. I wished to talk to him. I should have said [previously] that before I began to be hoisted from the deck of the *Consolation*, flying around the hospital ship two or three times, and then landing on the *Rochester*, I happened to look at my watch. The consumed time to make that entire trip was ten minutes.

As soon as Struble and I entered his cabin, I said, "Why not build a landing platform on the fantail of the hospital ships for helicopters to land thereon?"

Struble thought I was crazy as hell, he said, for even proposing such a screwball idea. I said no doubt many people thought I was at times, but in this instance I certainly was not. I felt my proposal was a very sound and practical measure.

He said, "I'll prove to you, Joel, how crazy you are." Thereupon he sent for his engineer officer, Rear Admiral George Henderson. Struble then narrated to Henderson my proposal. Instead of his agreeing with him, Henderson said, "Hell, why didn't we line officers think about it instead of some medical officer! It certainly is a practical idea." His observation naturally was a surprise to me, but was very gratifying. I knew the proposal, if it were carried out and the provision made on hospital ships, would greatly speed the evacuation of wounded and innumerable lives would be saved. As a result, it was recommended that landing platforms be built on hospital ships. I was pleased to learn later that Vice Admiral Struble and Rear Admiral J.H. Doyle [Amphibious Force Commander] favored the installations. ❑

Bibliography

Boone, Joel T. *Joel T. Boone Papers—Memoirs*, Library of Congress, Washington, DC, ch. XXXVII, pp.171-180, box 60. Courtesy of Milton F. Heller, Jr.

The* Consolation *returned to Long Beach where a helicopter deck was installed on her fantail. Back in Korean waters, the* Consolation*, the first hospital ship to be so equipped, took its first patient aboard by helicopter on 18 December 1950, inaugurating a new era in patient care.—Ed.

Book Review

Heller, Milton F., Jr. *The Presidents' Doctor: An Insider's View of Three First Families*. Vantage Press. New York. 2000, 200 pages.

Joel Thompson Boone was born on 29 August 1889 in St. Clair, PA, of Quaker parents. Three events influenced his future: his stepmother's suggestion that he attend Mercersburg Academy, which led to a lifelong association with that institution, his meeting Helen Elizabeth Koch at the age of 10 (she later became his wife), and, finally, his experience with his uncle, Dr. George Boone, a country general practice physician. It was that association that led the young Boone to attend Hahnemann Medical College in Philadelphia.

After graduation and a year of internship, another road opened for him at a dinner with his fiancé, Helen, and a distant relative, Uncle Charlie Dyson, who was a captain in the Navy. Dyson told Boone that doctors in the Navy received a regular paycheck. The prospect of having some financial security meant that a wedding date could be set. Despite Helen's reservations, Dr. Boone received a naval commission, and he and Helen were married on 20 June 1914.

Boone's first assignment was at the Portsmouth Naval Hospital in New Hampshire. Upon arriving there, Boone found himself chief of medicine, chief of neuropsychiatry, assistant in the Department of Surgery, and the pathologist.

From Portsmouth he was sent to the Navy Medical School in Washington, DC, and from there to Norfolk for assignment on the USS *Tennessee* to Haiti. In Haiti he was involved in the Caco uprising where he contracted estivo-autumnal malaria, which became so severe that on 20 June 1916, his second wedding anniversary, he was evacuated aboard the USS *Solace*. After recovery he was assigned to the U.S. Second Division and sailed for France and World War I.

His tour in France netted him two Croix de Guerre, the highest military honor bestowed by the French on a foreign military member, and the Medal of Honor, which helped lead him to his first assignment as Assistant Physician to the White House under President Harding, and medical officer of the Presidential Yacht, *Mayflower*.

Boone eventually served two terms as Assistant Physician to the White House under Presidents Harding and Coolidge, and then a third term as Physician to the White House under President Hoover. Boone's White House years were both rewarding and painful. He was with President Harding at his death. His relationship with the Coolidges was an enduring one, but the death of Calvin Coolidge Junior to infection brought him great sadness.

During World War II, Boone served as the Medical Officer of the Third Fleet under ADM William Halsey and represented the Navy Medical Department on the deck of the USS *Missouri* at the Japanese surrender on 2 September 1945.

Joel Boone served in several capacities after the war before retiring from the Navy in 1950. He then was Chief Medical Director of the Veterans Administration until retiring from that post and from government service in 1955.

VADM Boone's career and life epitomize the values of integrity, patriotism, service, and dedication to his patients, values that provide the foundation for Navy medicine. This biography of Joel Boone, the indispensable Navy physician, highlights the life of a man whose extraordinary career transcended many of the cataclysmic events of the first half of the 20th century.

The author, Milton Heller, is eminently qualified to write a biography of VADM Joel T. Boone. He not only knew him personally, he was also married to Admiral Boone's daughter, Suzanne. Because of his access to Dr. Boone's personal papers and journals as well as being a member of the family, the author is able to afford the reader a rare glimpse into the life of the Navy's most decorated physician. ❑

—Janice Marie Hores is Assistant Editor for *NAVY MEDICINE* Magazine, Bureau of Medicine and Surgery (MED-09H).

Navy Medicine 1953

Courtesy of LT Youssef H. Aboul-Enein, MSC, USN

Bird's eye view of hospital ship USS *Haven* (AH-12) from a helicopter about to land on the helo deck. USS *Consolation* (AH-15) lies off her starboard bow. The photo was taken on 14 August 1953 off the Korean coast by a Marine Corps photographer.